DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/23/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155187	B. WING			R-C 09/17/2013	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			17/2013
GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE				3175 LANCER ST PORTAGE, IN 46368			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS		{F 0	00}			
	This visit was for the Post Survey Revisit (PSR) to the investigation of Complaints IN00133670 and IN00134323 completed on 8/15/13.						
	This visit was in conjunction with the PSR to the Recertification and State Licensure Survey completed on 7/19/13.						
	Complaint IN0013367 Complaint IN0013432						
	Survey dates: September 16 &,17, 2013						
	Facility Number: 000 Provider Number: 15 AIM Number: 100290	5187					
	Survey Team: Heather Tuttle, R.N. Tyolanda Love, R.N.	г.С.					
	Census Bed Type: SNF/NF:146 Total: 146						
	Census Payor Type: Medicare: 28 Medicaid: 98 Other: 20 Total: 146						
	found to be in compliant Subpart B and 410 IA	-Fountainview Place was ance with 42 CFR Part 483, C 16.2 in regard to the PSR Complaints IN00133670					
ADODATODY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	DE		TITI F		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: 000098

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/23/2013 FORM APPROVED OMB NO. 0938-0391

NAME OF PROMIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE PAPER AND A CONTROL OF STATEMENT OF DEFICIENCING SUPPLIES AND A CONSTRUCTION OF STATEMENT OF DEFICIENCY	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FREFIX TAG COMPLETION DATE STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368 (X5) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (F 000) Quality review completed on September 22,	455405			D. MINO				
GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE 3175 LANCER ST PORTAGE, IN 46368 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (F 000) Continued From page 1 Quality review completed on September 22,	NAME OF D	POVIDED OD SLIDDLIED	155187	B. WING _	STREET ADDRESS CITY STATE 7ID CODE	09/17/2013		
GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE PORTAGE, IN 46368 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) FROM CONTINUED FROM PROPRIATE DEFICIENCY (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (FOUR CONTINUED FROM PROPRIATE DEFICIENCY) (FOUR CONTINUED FROM PROPRIATE DEFICIENCY)	NAME OF FI	ROVIDER OR SUFFLIER						
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE FROM [F 000] Continued From page 1 Quality review completed on September 22,	GOLDEN	LIVING CENTER-FOUNT	AINVIEW PLACE					
Quality review completed on September 22,	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	ILD BE COMPLETI	ON	
	{F 000}	Quality review comple	eted on September 22,	{F 00				